

SENATE BILL NO. 1339

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Education and Health

on _____)

(Patron Prior to Substitute--Senator Barker)

A BILL to amend and reenact §§ 32.1-27.1 and 32.1-127 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 32.1-27.2, relating to minimum staffing standards for certified nursing facilities; administrative sanctions.

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-27.1 and 32.1-127 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 32.1-27.2 as follows:

§ 32.1-27.1. Additional civil penalty or appointment of a receiver.

A. In addition to the remedies provided in ~~§§~~ §§ 32.1-27 and 32.1-27.2, the civil penalties set forth in this section may be imposed by the circuit court for the city or county in which the facility is located as follows:

1. A civil penalty for a Class I violation shall not exceed the lesser of \$25 per licensed or certified bed or \$1,000 for each day the facility is in violation, beginning on the date the facility was first notified of the violation.

2. A civil penalty for a Class II violation shall not exceed the lesser of \$5 per licensed or certified bed or \$250 per day for each day the facility is in violation, beginning on the date the facility was first notified of the violation.

In the event federal law or regulations require a civil penalty in excess of the amounts set forth above for Class I or Class II violations, then the lowest amounts required by such federal law or regulations shall become the maximum civil penalties under this section. The date of notification under this section shall be deemed to be the date of receipt by the facility of written notice of the alleged Class I or Class II

26 violation, which notice shall include specifics of the violation charged and which notice shall be hand
27 delivered or sent by overnight express mail or by registered or certified mail, return receipt requested.

28 All civil penalties received pursuant to this subsection shall be paid into a special fund of the
29 Department for the cost of implementation of this section, to be applied to the protection of the health or
30 property of residents or patients of facilities that the Commissioner or the United States Secretary of Health
31 and Human Services finds in violation, including payment for the costs for relocation of patients,
32 maintenance of temporary management or receivership to operate a facility pending correction of a
33 violation, and for reimbursement to residents or patients of lost personal funds.

34 B. In addition to the remedies provided in ~~§§ 32.1-27~~ and 32.1-27.2 and the civil penalties set
35 forth in subsection A ~~of this section~~, the Commissioner may petition the circuit court for the jurisdiction
36 in which any nursing home or certified nursing facility as defined in § 32.1-123 is located for the
37 appointment of a receiver in accordance with the provisions of this subsection whenever such nursing
38 home or certified nursing facility shall (i) receive official notice from the Commissioner that its license
39 has been or will be revoked or suspended, or that its Medicare or Medicaid certification has been or will
40 be cancelled or revoked; or (ii) receive official notice from the United States Department of Health and
41 Human Services or the Department of Medical Assistance Services that its provider agreement has been
42 or will be revoked, cancelled, terminated or not renewed; or (iii) advise the Department of its intention to
43 close or not to renew its license or Medicare or Medicaid provider agreement less than ninety days in
44 advance; or (iv) operate at any time under conditions which present a major and continuing threat to the
45 health, safety, security, rights or welfare of the patients, including the threat of imminent abandonment by
46 the owner or operator, or a pattern of failure to meet ongoing financial obligations such as the inability to
47 pay for essential food, pharmaceuticals, personnel, or required insurance; and (v) the Department is unable
48 to make adequate and timely arrangements for relocating all patients who are receiving medical assistance
49 under this chapter and Title XIX of the Social Security Act in order to ensure their continued safety and
50 health care.

51 Upon the filing of a petition for appointment of a receiver, the court shall hold a hearing within
52 ten days, at which time the Department and the owner or operator of the facility may participate and

53 present evidence. The court may grant the petition if it finds any one of the conditions identified in (i)
54 through (iv) ~~above~~ to exist in combination with the condition identified in (v) and the court further finds
55 that such conditions will not be remedied and that the patients will not be protected unless the petition is
56 granted.

57 No receivership established under this subsection shall continue in effect for more than 180 days
58 without further order of the court, nor shall the receivership continue in effect following the revocation of
59 the nursing home's license or the termination of the certified nursing facility's Medicare or Medicaid
60 provider agreement, except to enforce any post-termination duties of the provider as required by the
61 provisions of the Medicare or Medicaid provider agreement.

62 The appointed receiver shall be a person licensed as nursing home administrator in the
63 Commonwealth pursuant to Title 54.1 or, if not so licensed, shall employ and supervise a person so
64 licensed to administer the day-to-day business of the nursing home or certified nursing facility.

65 The receiver shall have (i) such powers and duties to manage the nursing home or certified nursing
66 facility as the court may grant and direct, including but not limited to the duty to accomplish the orderly
67 relocation of all patients and the right to refuse to admit new patients during the receivership, (ii) the
68 power to receive, conserve, protect and disburse funds, including Medicare and Medicaid payments on
69 behalf of the owner or operator of the nursing home or certified nursing facility, (iii) the power to execute
70 and avoid executory contracts, (iv) the power to hire and discharge employees, and (v) the power to do all
71 other acts, including the filing of such reports as the court may direct, subject to accounting to the court
72 therefor and otherwise consistent with state and federal law, necessary to protect the patients from the
73 threat or threats set forth in the original petitions, as well as such other threats arising thereafter or out of
74 the same conditions.

75 The court may grant injunctive relief as it deems appropriate to the Department or to its receiver
76 either in conjunction with or subsequent to the granting of a petition for appointment of a receiver under
77 this section.

78 The court may terminate the receivership on the motion of the Department, the receiver, or the
79 owner or operator, upon finding, after a hearing, that either (i) the conditions described in the petition have

80 been substantially eliminated or remedied, or (ii) all patients in the nursing home or certified nursing
81 facility have been relocated. Within ~~thirty~~ 30 days after such termination, the receiver shall file a complete
82 report of his activities with the court, including an accounting for all property of which he has taken
83 possession and all funds collected.

84 All costs of administration of a receivership hereunder shall be paid by the receiver out of
85 reimbursement to the nursing home or certified nursing facility from Medicare, Medicaid and other patient
86 care collections. The court, after terminating such receivership, shall enter appropriate orders to ensure
87 such payments upon its approval of the receiver's reports.

88 A receiver appointed under this section shall be an officer of the court, shall not be liable for
89 conditions at the nursing home or certified nursing facility which existed or originated prior to his
90 appointment and shall not be personally liable, except for his own gross negligence and intentional acts
91 which result in injuries to persons or damage to property at the nursing home or certified nursing facility
92 during his receivership.

93 The provisions of this subsection shall not be construed to relieve any owner, operator or other
94 party of any duty imposed by law or of any civil or criminal liability incurred by reason of any act or
95 omission of such owner, operator, or other party.

96 **§ 32.1-27.2. Administrative sanctions.**

97 A. Notwithstanding any other provision of law, the Commissioner may impose administrative
98 sanctions in accordance with this section on any certified nursing facility, if that certified nursing facility
99 does not comply with the provisions of regulations promulgated pursuant to subdivision B 32 of § 32.1-
100 127. The Commissioner shall not impose any administrative sanctions authorized under this section until
101 regulations are promulgated pursuant to subsection G.

102 B. The Commissioner shall have authority to annually determine whether or not to impose any
103 sanctions under subsection C for noncompliance with the provisions of regulations promulgated pursuant
104 to subdivision B 32 of § 32.1-127, if the certified nursing facility:

105 1. Was affected by a declared emergency, or an act of God, that had an impact on the ability to
106 hire or retain staff at levels required under subdivision B 32 of § 32.1-127. To the extent necessary, the

107 Commissioner may review trended employment data for direct care staff, as provided by the certified
108 nursing facility, to determine the effect of such emergencies or acts of God in assessing this criterion.
109 Failure to provide adequate data may remove this criterion from the Commissioner's consideration;

110 2. Has made a concerted effort to recruit and retain direct care staff as evidenced through position
111 advertisements, interviews, offers, financial incentives, and nonfinancial incentives. The certified nursing
112 facility shall provide such evidence upon request of the Commissioner for consideration. Failure to
113 provide adequate evidence may remove this criterion from the Commissioner's consideration; or

114 3. Was located in a medically underserved area and such location severely limited the ability of
115 the certified nursing facility to recruit and retain direct care staff despite a concerted effort to recruit and
116 retain direct care staff. The certified nursing facility shall provide evidence upon request of the
117 Commissioner for consideration. Failure to provide adequate evidence may remove this criterion from the
118 Commissioner's consideration.

119 C. Prior to restricting or prohibiting new admissions to a certified nursing facility, suspending or
120 refusing to renew or reinstate any nursing home license, or revoking any nursing home license issued
121 pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5, the Commissioner shall first impose the following
122 iterative administrative sanctions:

123 1. When a certified nursing facility is not in compliance with subdivision B 32 of § 32.1-127 and
124 the conditions under subsection B do not exist, the Commissioner shall require the submission of an annual
125 corrective action plan by a certified nursing facility and, upon approval of such plan by the Commissioner,
126 compliance with such plan. A corrective action plan shall only articulate strategies to be utilized to
127 increase direct care staffing with the goal of compliance with subdivision B 32 of § 32.1-127 or
128 improvement on the total nurse staffing hours metric, as defined by the Virginia Medicaid Nursing Facility
129 Value-Based Purchasing (VBP) program. The Commissioner shall consider evidence of direct care staff
130 hours provided in addition to the payroll based journal report, if requested by a certified nursing facility,
131 and may or may not impose a corrective action plan under this section. The Commissioner shall consider
132 the following:

133 a. If the annual measurement immediately subsequent to issuance of the corrective action plan
134 shows compliance with subdivision B 32 of § 32.1-127, no additional administrative sanctions are
135 warranted, and the corrective action plan is deemed inactive but shall be retained by the Commissioner
136 pursuant to the Virginia Public Records Act (§ 42.1-76 et seq.); or

137 b. If the annual measurement immediately subsequent to issuance of the corrective action plan still
138 shows noncompliance with subdivision B 32 of § 32.1-127, but the VBP program, as administered by the
139 Department of Medical Assistance Services, indicates defined improvement on the total nurse staffing
140 hours metric, the Commissioner shall repeat the provisions of subdivision 1; or

141 c. If the annual measurement immediately subsequent to issuance of the corrective action plan still
142 shows noncompliance with subdivision B 32 of § 32.1-127, and the VBP program, as administered by the
143 Department of Medical Assistance Services, does not indicate defined improvement on the total nurse
144 staffing hours metric, the Commissioner shall repeat the provisions of subdivision 1 and may, under
145 circumstances described, provide additional sanctions under subdivisions 2 and 3;

146 2. To the extent that any consecutive annual corrective action plan is required and results
147 articulated in subdivision 1 c are obtained a second consecutive time, the Commissioner may impose a
148 monetary penalty of up to \$50,000 for each subsequent consecutive annual period in which compliance
149 with subdivision B 32 of § 32.1-127 or defined improvement on the total nurse staffing hours metric under
150 the VBP program is not attained; and

151 3. To the extent that a certified nursing facility is out of compliance with subdivision B 32 of §
152 32.1-127 or fails to show defined improvement on the total nurse staffing hours metric under the VBP
153 program after three consecutive corrective action plans, the Commissioner may place the nursing home
154 or certified nursing facility on probation.

155 D. A certified nursing facility sanctioned by the Commissioner shall retain responsibility for the
156 health, safety, and welfare of any person under its care, including the timely transfer or relocation of such
157 persons as may be deemed necessary by the Commissioner in compliance with state and federal discharge
158 rights and protections for nursing home residents.

159 E. After deduction of the administrative costs of the Commissioner and the Department in
160 furtherance of this section, any penalties collected under this section shall be paid to the special fund as
161 set forth in § 32.1-27.1.

162 F. Prior to imposing administrative sanctions, the Commissioner shall provide the facility with
163 reasonable notice. To the extent that sanctions are imposed, the facility shall be entitled to all rights under
164 the Administrative Process Act (§ 2.2-4000 et seq.) and to a de novo appeal to circuit court.

165 G. The Board shall promulgate regulations to implement the provisions of this section consistent
166 with the Administrative Process Act (§ 2.2-4000 et seq.).

167 **§ 32.1-127. Regulations.**

168 A. The regulations promulgated by the Board to carry out the provisions of this article shall be in
169 substantial conformity to the standards of health, hygiene, sanitation, construction and safety as
170 established and recognized by medical and health care professionals and by specialists in matters of public
171 health and safety, including health and safety standards established under provisions of Title XVIII and
172 Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

173 B. Such regulations:

174 1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing
175 homes and certified nursing facilities to ensure the environmental protection and the life safety of its
176 patients, employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes
177 and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and
178 certified nursing facilities, except those professionals licensed or certified by the Department of Health
179 Professions; (iv) conditions under which a hospital or nursing home may provide medical and nursing
180 services to patients in their places of residence; and (v) policies related to infection prevention, disaster
181 preparedness, and facility security of hospitals, nursing homes, and certified nursing facilities;

182 2. Shall provide that at least one physician who is licensed to practice medicine in this
183 Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at
184 each hospital which operates or holds itself out as operating an emergency service;

185 3. May classify hospitals and nursing homes by type of specialty or service and may provide for
186 licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

187 4. Shall also require that each hospital establish a protocol for organ donation, in compliance with
188 federal law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42
189 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization
190 designated in CMS regulations for routine contact, whereby the provider's designated organ procurement
191 organization certified by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients
192 in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ
193 donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified
194 by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for
195 tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at
196 least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of
197 tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid
198 interference with organ procurement. The protocol shall ensure that the hospital collaborates with the
199 designated organ procurement organization to inform the family of each potential donor of the option to
200 donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall
201 have completed a course in the methodology for approaching potential donor families and requesting
202 organ or tissue donation that (a) is offered or approved by the organ procurement organization and
203 designed in conjunction with the tissue and eye bank community and (b) encourages discretion and
204 sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition,
205 the hospital shall work cooperatively with the designated organ procurement organization in educating the
206 staff responsible for contacting the organ procurement organization's personnel on donation issues, the
207 proper review of death records to improve identification of potential donors, and the proper procedures
208 for maintaining potential donors while necessary testing and placement of potential donated organs,
209 tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the
210 relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer

211 of the hospital or his designee knows of such opposition, and no donor card or other relevant document,
212 such as an advance directive, can be found;

213 5. Shall require that each hospital that provides obstetrical services establish a protocol for
214 admission or transfer of any pregnant woman who presents herself while in labor;

215 6. Shall also require that each licensed hospital develop and implement a protocol requiring written
216 discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall
217 require that the discharge plan be discussed with the patient and that appropriate referrals for the mother
218 and the infant be made and documented. Appropriate referrals may include, but need not be limited to,
219 treatment services, comprehensive early intervention services for infants and toddlers with disabilities and
220 their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et
221 seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent
222 possible, the other parent of the infant and any members of the patient's extended family who may
223 participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant
224 to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal
225 law restrictions, the community services board of the jurisdiction in which the woman resides to appoint
226 a discharge plan manager. The community services board shall implement and manage the discharge plan;

227 7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant
228 for admission the home's or facility's admissions policies, including any preferences given;

229 8. Shall require that each licensed hospital establish a protocol relating to the rights and
230 responsibilities of patients which shall include a process reasonably designed to inform patients of such
231 rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to
232 patients on admission, shall be consistent with applicable federal law and regulations of the Centers for
233 Medicare and Medicaid Services;

234 9. Shall establish standards and maintain a process for designation of levels or categories of care
235 in neonatal services according to an applicable national or state-developed evaluation system. Such
236 standards may be differentiated for various levels or categories of care and may include, but need not be
237 limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;

238 10. Shall require that each nursing home and certified nursing facility train all employees who are
239 mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting
240 procedures and the consequences for failing to make a required report;

241 11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations,
242 or hospital policies and procedures, to accept emergency telephone and other verbal orders for medication
243 or treatment for hospital patients from physicians, and other persons lawfully authorized by state statute
244 to give patient orders, subject to a requirement that such verbal order be signed, within a reasonable period
245 of time not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or
246 hospital policies and procedures, by the person giving the order, or, when such person is not available
247 within the period of time specified, co-signed by another physician or other person authorized to give the
248 order;

249 12. Shall require, unless the vaccination is medically contraindicated or the resident declines the
250 offer of the vaccination, that each certified nursing facility and nursing home provide or arrange for the
251 administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal
252 vaccination, in accordance with the most recent recommendations of the Advisory Committee on
253 Immunization Practices of the Centers for Disease Control and Prevention;

254 13. Shall require that each nursing home and certified nursing facility register with the Department
255 of State Police to receive notice of the registration, reregistration, or verification of registration
256 information of any person required to register with the Sex Offender and Crimes Against Minors Registry
257 pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 within the same or a contiguous zip code area in
258 which the home or facility is located, pursuant to § 9.1-914;

259 14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission,
260 whether a potential patient is required to register with the Sex Offender and Crimes Against Minors
261 Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, if the home or facility anticipates the
262 potential patient will have a length of stay greater than three days or in fact stays longer than three days;

263 15. Shall require that each licensed hospital include in its visitation policy a provision allowing
264 each adult patient to receive visits from any individual from whom the patient desires to receive visits,

265 subject to other restrictions contained in the visitation policy including, but not limited to, those related to
266 the patient's medical condition and the number of visitors permitted in the patient's room simultaneously;

267 16. Shall require that each nursing home and certified nursing facility shall, upon the request of
268 the facility's family council, send notices and information about the family council mutually developed by
269 the family council and the administration of the nursing home or certified nursing facility, and provided
270 to the facility for such purpose, to the listed responsible party or a contact person of the resident's choice
271 up to six times per year. Such notices may be included together with a monthly billing statement or other
272 regular communication. Notices and information shall also be posted in a designated location within the
273 nursing home or certified nursing facility. No family member of a resident or other resident representative
274 shall be restricted from participating in meetings in the facility with the families or resident representatives
275 of other residents in the facility;

276 17. Shall require that each nursing home and certified nursing facility maintain liability insurance
277 coverage in a minimum amount of \$1 million, and professional liability coverage in an amount at least
278 equal to the recovery limit set forth in § 8.01-581.15, to compensate patients or individuals for injuries
279 and losses resulting from the negligent or criminal acts of the facility. Failure to maintain such minimum
280 insurance shall result in revocation of the facility's license;

281 18. Shall require each hospital that provides obstetrical services to establish policies to follow
282 when a stillbirth, as defined in § 32.1-69.1, occurs that meet the guidelines pertaining to counseling
283 patients and their families and other aspects of managing stillbirths as may be specified by the Board in
284 its regulations;

285 19. Shall require each nursing home to provide a full refund of any unexpended patient funds on
286 deposit with the facility following the discharge or death of a patient, other than entrance-related fees paid
287 to a continuing care provider as defined in § 38.2-4900, within 30 days of a written request for such funds
288 by the discharged patient or, in the case of the death of a patient, the person administering the person's
289 estate in accordance with the Virginia Small Estates Act (§ 64.2-600 et seq.);

290 20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol
291 that requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct

292 verbal communication between the on-call physician in the psychiatric unit and the referring physician, if
293 requested by such referring physician, and prohibits on-call physicians or other hospital staff from refusing
294 a request for such direct verbal communication by a referring physician and (ii) a patient for whom there
295 is a question regarding the medical stability or medical appropriateness of admission for inpatient
296 psychiatric services due to a situation involving results of a toxicology screening, the on-call physician in
297 the psychiatric unit to which the patient is sought to be transferred to participate in direct verbal
298 communication, either in person or via telephone, with a clinical toxicologist or other person who is a
299 Certified Specialist in Poison Information employed by a poison control center that is accredited by the
300 American Association of Poison Control Centers to review the results of the toxicology screen and
301 determine whether a medical reason for refusing admission to the psychiatric unit related to the results of
302 the toxicology screen exists, if requested by the referring physician;

303 21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall
304 develop a policy governing determination of the medical and ethical appropriateness of proposed medical
305 care, which shall include (i) a process for obtaining a second opinion regarding the medical and ethical
306 appropriateness of proposed medical care in cases in which a physician has determined proposed care to
307 be medically or ethically inappropriate; (ii) provisions for review of the determination that proposed
308 medical care is medically or ethically inappropriate by an interdisciplinary medical review committee and
309 a determination by the interdisciplinary medical review committee regarding the medical and ethical
310 appropriateness of the proposed health care; and (iii) requirements for a written explanation of the decision
311 reached by the interdisciplinary medical review committee, which shall be included in the patient's
312 medical record. Such policy shall ensure that the patient, his agent, or the person authorized to make
313 medical decisions pursuant to § 54.1-2986 (a) are informed of the patient's right to obtain his medical
314 record and to obtain an independent medical opinion and (b) afforded reasonable opportunity to participate
315 in the medical review committee meeting. Nothing in such policy shall prevent the patient, his agent, or
316 the person authorized to make medical decisions pursuant to § 54.1-2986 from obtaining legal counsel to
317 represent the patient or from seeking other remedies available at law, including seeking court review,
318 provided that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-

319 2986, or legal counsel provides written notice to the chief executive officer of the hospital within 14 days
320 of the date on which the physician's determination that proposed medical treatment is medically or
321 ethically inappropriate is documented in the patient's medical record;

322 22. Shall require every hospital with an emergency department to establish protocols to ensure that
323 security personnel of the emergency department, if any, receive training appropriate to the populations
324 served by the emergency department, which may include training based on a trauma-informed approach
325 in identifying and safely addressing situations involving patients or other persons who pose a risk of harm
326 to themselves or others due to mental illness or substance abuse or who are experiencing a mental health
327 crisis;

328 23. Shall require that each hospital establish a protocol requiring that, before a health care provider
329 arranges for air medical transportation services for a patient who does not have an emergency medical
330 condition as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized
331 representative with written or electronic notice that the patient (i) may have a choice of transportation by
332 an air medical transportation provider or medically appropriate ground transportation by an emergency
333 medical services provider and (ii) will be responsible for charges incurred for such transportation in the
334 event that the provider is not a contracted network provider of the patient's health insurance carrier or such
335 charges are not otherwise covered in full or in part by the patient's health insurance plan;

336 24. Shall establish an exemption from the requirement to obtain a license to add temporary beds
337 in an existing hospital or nursing home, including beds located in a temporary structure or satellite location
338 operated by the hospital or nursing home, provided that the ability remains to safely staff services across
339 the existing hospital or nursing home, (i) for a period of no more than the duration of the Commissioner's
340 determination plus 30 days when the Commissioner has determined that a natural or man-made disaster
341 has caused the evacuation of a hospital or nursing home and that a public health emergency exists due to
342 a shortage of hospital or nursing home beds or (ii) for a period of no more than the duration of the
343 emergency order entered pursuant to § 32.1-13 or 32.1-20 plus 30 days when the Board, pursuant to §
344 32.1-13, or the Commissioner, pursuant to § 32.1-20, has entered an emergency order for the purpose of

345 suppressing a nuisance dangerous to public health or a communicable, contagious, or infectious disease
346 or other danger to the public life and health;

347 25. Shall establish protocols to ensure that any patient scheduled to receive an elective surgical
348 procedure for which the patient can reasonably be expected to require outpatient physical therapy as a
349 follow-up treatment after discharge is informed that he (i) is expected to require outpatient physical
350 therapy as a follow-up treatment and (ii) will be required to select a physical therapy provider prior to
351 being discharged from the hospital;

352 26. Shall permit nursing home staff members who are authorized to possess, distribute, or
353 administer medications to residents to store, dispense, or administer cannabis oil to a resident who has
354 been issued a valid written certification for the use of cannabis oil in accordance with subsection B of §
355 54.1-3408.3 and has registered with the Board of Pharmacy;

356 27. Shall require each hospital with an emergency department to establish a protocol for the
357 treatment and discharge of individuals experiencing a substance use-related emergency, which shall
358 include provisions for (i) appropriate screening and assessment of individuals experiencing substance use-
359 related emergencies to identify medical interventions necessary for the treatment of the individual in the
360 emergency department and (ii) recommendations for follow-up care following discharge for any patient
361 identified as having a substance use disorder, depression, or mental health disorder, as appropriate, which
362 may include, for patients who have been treated for substance use-related emergencies, including opioid
363 overdose, or other high-risk patients, (a) the dispensing of naloxone or other opioid antagonist used for
364 overdose reversal pursuant to subsection X of § 54.1-3408 at discharge or (b) issuance of a prescription
365 for and information about accessing naloxone or other opioid antagonist used for overdose reversal,
366 including information about accessing naloxone or other opioid antagonist used for overdose reversal at a
367 community pharmacy, including any outpatient pharmacy operated by the hospital, or through a
368 community organization or pharmacy that may dispense naloxone or other opioid antagonist used for
369 overdose reversal without a prescription pursuant to a statewide standing order. Such protocols may also
370 provide for referrals of individuals experiencing a substance use-related emergency to peer recovery

371 specialists and community-based providers of behavioral health services, or to providers of
372 pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

373 28. During a public health emergency related to COVID-19, shall require each nursing home and
374 certified nursing facility to establish a protocol to allow each patient to receive visits, consistent with
375 guidance from the Centers for Disease Control and Prevention and as directed by the Centers for Medicare
376 and Medicaid Services and the Board. Such protocol shall include provisions describing (i) the conditions,
377 including conditions related to the presence of COVID-19 in the nursing home, certified nursing facility,
378 and community, under which in-person visits will be allowed and under which in-person visits will not be
379 allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will
380 be required to comply to protect the health and safety of the patients and staff of the nursing home or
381 certified nursing facility; (iii) the types of technology, including interactive audio or video technology,
382 and the staff support necessary to ensure visits are provided as required by this subdivision; and (iv) the
383 steps the nursing home or certified nursing facility will take in the event of a technology failure, service
384 interruption, or documented emergency that prevents visits from occurring as required by this subdivision.
385 Such protocol shall also include (a) a statement of the frequency with which visits, including virtual and
386 in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each
387 patient; (b) a provision authorizing a patient or the patient's personal representative to waive or limit
388 visitation, provided that such waiver or limitation is included in the patient's health record; and (c) a
389 requirement that each nursing home and certified nursing facility publish on its website or communicate
390 to each patient or the patient's authorized representative, in writing or via electronic means, the nursing
391 home's or certified nursing facility's plan for providing visits to patients as required by this subdivision;

392 29. Shall require each hospital, nursing home, and certified nursing facility to establish and
393 implement policies to ensure the permissible access to and use of an intelligent personal assistant provided
394 by a patient, in accordance with such regulations, while receiving inpatient services. Such policies shall
395 ensure protection of health information in accordance with the requirements of the federal Health
396 Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d et seq., as amended. For the
397 purposes of this subdivision, "intelligent personal assistant" means a combination of an electronic device

398 and a specialized software application designed to assist users with basic tasks using a combination of
399 natural language processing and artificial intelligence, including such combinations known as "digital
400 assistants" or "virtual assistants";

401 30. During a declared public health emergency related to a communicable disease of public health
402 threat, shall require each hospital, nursing home, and certified nursing facility to establish a protocol to
403 allow patients to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or
404 sect consistent with guidance from the Centers for Disease Control and Prevention and the Centers for
405 Medicare and Medicaid Services and subject to compliance with any executive order, order of public
406 health, Department guidance, or any other applicable federal or state guidance having the effect of limiting
407 visitation. Such protocol may restrict the frequency and duration of visits and may require visits to be
408 conducted virtually using interactive audio or video technology. Any such protocol may require the person
409 visiting a patient pursuant to this subdivision to comply with all reasonable requirements of the hospital,
410 nursing home, or certified nursing facility adopted to protect the health and safety of the person, patients,
411 and staff of the hospital, nursing home, or certified nursing facility; ~~and~~

412 31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of
413 patients who are minors available to such patients through a secure website shall make such health records
414 available to such patient's parent or guardian through such secure website, unless the hospital cannot make
415 such health record available in a manner that prevents disclosure of information, the disclosure of which
416 has been denied pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance
417 with subsection E of § 54.1-2969 has not been provided; and

418 32. Shall require each certified nursing facility eligible to participate in the Virginia Medicaid
419 Nursing Facility Value-Based Purchasing (VBP) program, as referenced in Chapter 2 of the Acts of
420 Assembly of 2022, Special Session I, to provide at least 3.08 hours of case mix-adjusted total nurse staffing
421 hours per resident per day on average as determined annually by the Department of Medical Assistance
422 Services for use in the VBP program, utilizing job codes for the calculation of total nurse staffing hours
423 per resident per day following the Centers for Medicare and Medicaid Services (CMS) definitions as of
424 January 1, 2022, used for similar purposes and including certified nursing assistants, licensed practical

425 nurses, and registered nurses. No additional reporting shall be required by a certified nursing facility under
426 this subdivision.

427 C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and
428 certified nursing facilities may operate adult day care centers.

429 D. All facilities licensed by the Board pursuant to this article which provide treatment or care for
430 hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot
431 numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to
432 be contaminated with an infectious agent, those hemophiliacs who have received units of this
433 contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot
434 that is known to be contaminated shall notify the recipient's attending physician and request that he notify
435 the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return
436 receipt requested, each recipient who received treatment from a known contaminated lot at the individual's
437 last known address.

438 E. Hospitals in the Commonwealth may enter into agreements with the Department of Health for
439 the provision to uninsured patients of naloxone or other opioid antagonists used for overdose reversal.

440 **2. That without initial and ongoing funding for the state share of the cost to implement the provisions**
441 **of this act, as built in to the calculation and application of the base Medicaid rates, the State Health**
442 **Commissioner shall not impose administrative sanctions in accordance with § 32.1-27.2 of the Code**
443 **of Virginia, as created by this act, on any certified nursing home that does not comply with the**
444 **provisions of regulations promulgated pursuant to subdivision B 32 of § 32.1-127 of the Code of**
445 **Virginia, as amended by this act. In any period in which the calculated Medicaid Virginia Nursing**
446 **Home Inflation Index is not fully implemented, administrative sanctions in accordance with § 32.1-**
447 **27.2 of the Code of Virginia, as created by this act, shall be suspended.**

448 **3. That if the funding of the Value-Based Purchasing program is reduced or suspended below levels**
449 **established in the 2022 Appropriation Act (Chapter 2 of the Acts of Assembly of 2022, Special**
450 **Session I), as adjusted by the Medicaid Virginia Nursing Home Inflation Index annually thereafter,**
451 **the State Health Commissioner shall not impose administrative sanctions in accordance with § 32.1-**

452 27.2 of the Code of Virginia, as created by this act, on any certified nursing home that does not
453 comply with the provisions of regulations promulgated pursuant to subdivision B 32 of § 32.1-127
454 of the Code of Virginia, as amended by this act.

455 4. That in the event that a federal staffing ratio or similar mandate is established, the staffing ratio
456 established pursuant to subdivision B 32 of § 32.1-127 of the Code of Virginia, as amended by this
457 act, shall be repealed. In such an event, authority for administrative sanctions in accordance with §
458 32.1-27.2 of the Code of Virginia, as created by this act, shall be revoked, with deferral to federal
459 authority to enforce the staffing ratio or similar mandate under federal law.

460 5. That annually the Department of Medical Assistance Services shall communicate to the State
461 Board of Health the information required by the provisions of subdivision B 32 of § 32.1-127 of the
462 Code of Virginia, as amended by this act, and the State Board of Health shall not include the
463 provisions of subdivision B 32 of § 32.1-127 of the Code of Virginia, as amended by this act, in the
464 state licensure requirements. The information that the Department of Medical Assistance Services
465 is required to communicate to the State Board of Health under this enactment shall apply to the
466 Virginia Medicaid Nursing Facility Value-Based Purchasing program as referenced in Chapter 2
467 of the Acts of Assembly of 2022, Special Session I, or its successor programs.

468 6. That in the event that the Centers for Medicare and Medicaid Services amends, revises, or deletes
469 the payroll base journal reporting requirements, forms, and processes after January 1, 2022, to such
470 an extent that it impacts the ability of the Commissioner to determine compliance, the Department
471 of Medical Assistance Services shall convene with the State Board of Health a stakeholder work
472 group to make recommendations to the Chairman of the House Committee on Health, Welfare and
473 Institutions and the Chairman of the Senate Committee on Education and Health on what process
474 will be used for determining the equivalent staffing ratio to that designated under subdivision B 32
475 of § 32.1-127 of the Code of Virginia, as amended by this act, relative to the federal methodology
476 changes or reporting to support the ratio established under the previous federal methodology.

477 7. That in the event that the Department of Medical Assistance Services stops calculating the staffing
478 standard as referenced in subdivision B 32 of § 32.1-127 of the Code of Virginia, as amended by this

479 act, notice shall be given to the State Board of Health and a work group shall be convened by the
480 Department of Medical Assistance Services along with the State Board of Health and stakeholders
481 to make recommendations to the Chairmen of the House Committee on Health, Welfare and
482 Institutions and the Senate Committee on Education and Health on what process will be used for
483 determining the equivalent staffing ratio to that designated under subdivision B 32 of § 32.1-127 of
484 the Code of Virginia, as amended by this act, relative to how the calculations can be made and what
485 fiscal implications, if any, may result.

486 8. That the provisions of the first enactment of this act shall become effective on July 1, 2025.

487 9. That the State Health Commissioner, in collaboration with the Department of Medical Assistance
488 Services, shall, in consultation with relevant stakeholder groups, review and consider modifications
489 to the minimum nurse staffing standard articulated in subdivision B 32 of § 32.1-127 of the Code of
490 Virginia, as amended by this act, every four years from the effective date of the first enactment of
491 this act. Upon completion of each required review, the State Health Commissioner shall submit his
492 findings and recommendations regarding modification of the minimum nurse staffing standard to
493 the Governor and the Chairmen of the House Committees on Health, Welfare and Institutions and
494 Appropriations and the Senate Committees on Education and Health and Finance and
495 Appropriations prior to the next regular session of the General Assembly.

496 10. That the State Board of Health shall promulgate regulations consistent with the provisions of
497 the first enactment of this act consistent with its passage.

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